

# HIV/AIDS prevention campaigns from a Thai Buddhist perspective

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The AIDS pandemic came to Thai public notice in 1984. It has since spread from men who had sex with men, to injecting drug users, to sex workers, to the male population at large, and finally to the partners of the males and their children. A survey conducted in 2002 by UNAIDS, UNICEF & WHO found that, at the end of 2001, there were 650,000 infected adults (i.e. 15-49 years of age), 220,000 of these were females. In addition, there were 21,000 infected children (0-15 years) and the ratio of males/females who live with HIV/AIDS has shifted from 4:1 to 2:1 during the last decade.

Buddhism is the mainstream religion in Thailand, as 97% percent of the population claim to be Buddhists. There are more than 30,000 temples situated all over the country. These temples house more than 200,000 monks and novices all together. (Visalo, 2003: 6). Traditionally monks are supposed to study Pali (the ancient language by which Buddha taught in India), the dharma (doctrines/ultimate reality), Vinaya (disciplines), and practice meditation to uplift their spiritual well-being (Klausner 1993: 160).

Today, monks cannot detach themselves from being the populace's spiritual leaders. While urban monks' roles are often limited to the study of Pali, meditation, teaching dharma, performing rites and ceremonies, village monks have been organising various projects. Village monks who practice selflessness are also expected to devote themselves to social work. These monks are called pra nakpattana or monk-developers (Jackson 2003: 206-215).

## **From a media advocacy and social marketing approach**

The initial official 'answer' of Thailand to the emergence of the first AIDS case in 1984 was silence. The government was afraid that it would affect tourism and cause a public panic (Baltimore Sun 2002, p.2). This policy changed gradually from avoidance to acceptance in the late 1980s. The then Thai government assigned the Ministry of Public Health to play an official role in the national AIDS campaigns. Between 1989 and 1992 the '100% condom use in brothels' campaign was launched. The campaign was to prevent sex clients from purchasing sexual services unless they used a condom. The current Prime Minister, Thaksin Shinawatra, stated at the 2001 seventh meeting of the Association of Southeast Asian Nations (ASEAN) in Brunei that this was the most significant strategy change. The 100% condom strategy was officially adopted in 1991 when the Prime Minister took the chair of the National AIDS committee. It took the government six more years to set up the National AIDS Foundation in 1997.

A summary of 26 research projects on mass media and HIV/AIDS in Thailand, executed during 1990-96, concluded that negative messages to frighten the public were the most prominent communication strategy applied in this period, mainly transmitted through government ads on television. The messages brand the people who contracted HIV negatively. The public's reaction was to negate or ignore news about HIV/AIDS, and to discriminate against infected people. This created misunderstanding among the public and caused anxiety and hopelessness among infected people (Sthapitanonda, Kunphai, Jatiket & Jatiket 2003: 37-53).

Ms. Prudence Borthwick, the UNICEF coordinator for the AIDS in Thailand project, commented that:

'It soon became apparent in Thailand, as elsewhere, that lurid photographic enlargements of herpes zoster blisters or other opportunistic infections displayed as clinical models of disease prevention were not the best way for the public to be informed about HIV/AIDS' (Borthwick 1999: 209-10).

The social marketing approach has gradually shifted to the use of positive campaign strategies. Top-down approaches, such as those giving moral support, avoiding branding names or creating emotional appeal, are widely used now by the Ministry of Public Health and other governmental organizations (Sthapitanonda, Kunphai, Jatiket & Jatiket 2003: 178-9). However, from 1997 onwards another shift became visible, which got referred to as the bottom-up approach.

? towards a community-based approach

1997 was a bad year for the Thai economy. Thailand had to devalue its currency and sign a contract to get loans from the IMF. These events raised public awareness about the failure of imposing Western concepts of democracy, industrialization, and modernization and so forth without reflecting on the set of values and the worldview of Thais. Thailand, then, decided to aim for a more sustainable or ?sufficient? economy and civic society, as stated for the first time in 1998 in the National Agenda proposed by Praves Wasi, one of the leading scholars and Buddhist activists in Thailand (Wasi 2003: 1). ?Sufficient economy? is a concept of King Bhumibol, King of Thailand. It advocates an endogenous approach based on the Buddhist philosophy of becoming self-reliant on the basis of integrating strong communities, the environment, culture, quality of life, generosity, compassion and local intellect (Wasi 2003: 4-5).

Praves Wasi defined a strong community as a community where the people:

?? get organized and share the same objectives; they provide mutual assistance; together they go through different learning experiences and develop good management systems. Strong communities are capable of resolving poverty issues, conserving natural resources and prevention and solving social ills such as violence, substance abuse, and prostitute recruitment? (Wasi n.d: 10).

The community-based development approach is thus seen as a solution to the cause of the HIV/AIDS epidemic. Therefore, a UNAIDS report on funding priorities for the HIV/AIDS crisis in Thailand stated that:

?In the national AIDS control and prevention plan (1997-2001), the AIDS programme budget is not solely a financing source for HIV/AIDS control. Rather, it is a catalyst for mobilizing and reorienting the use of resources from public and private sectors, families and the community at large.?(UNAIDS n.d: 14).

One can see that the national AIDS policy has changed over a decade from an individualistic approach (increasing info/awareness) to a collective social approach as one can see the paradigm shift from the National AIDS Plan during 1992-96 to the strategic plan during 1997-2001 (Poolcharoen 1998: 39).

### **A Buddhist model?**

When talking about culture, one cannot deny that religion plays a major role in its symbolic representation. Berger and Luckmann explain in *The Social Construction of Reality* (1966) the interaction between thinking and actions. Socialization within a tradition and culture shape an individual?s internal thinking, and at the same time this internalized form is reflected in the manifestation of culture (Holm 1997: 75). This model stresses the importance of religion as it may provide a symbolic universe, which explains birth, life, and death, as well as providing the individual with an identity.

Religion explains the world through myths and legends and through rational discourses. Ideas, rituals and religious institutions (Kurtz 1995: 47-48) construct the world of the believers. Meredith McGuire stated that official forms of religion are much less important than the religious situation that we had been led to believe. She argues that to know how religion is employed as a cultural resource, we need to focus on its process and:

??we should pay particular attention to rituals, symbols, and other vehicles for world images (whether toward change or preservation) and for shared religious experiences and sense of community. We need greater attention especially to language ? such as shared symbolic language, narratives of personal meanings and group experiences, and the structures of discourse and how it develops and changes? (McGuire 2002: 124-5).

In his *History of Sexuality and Christianity*, Foucault stated that sexuality was produced through the strategies of power-knowledge. He identified Christianity (and in consequence religion) as a fundamental mechanism of power. According to him the religious institution is part of the ?coercive technologies of behaviour? (Foucault quoted in Carrette 2004: 31). McGuire added that the people who had religious power in a social group are often inclined to control the use of sexual power because they view it as a possible threat to the power base (McGuire 2002: 137). She stated that, ?Religion is not only an experience of power but often also results in the sense of being empowered? (McGuire 2002: 255).

McGuire pointed out that religion has had a direct impact on legitimating gender caste stratifications, e.g. through religious laws, and an indirect impact through rituals and symbols that reinforce ideas of women?s inferiority. According to her, religion legitimates what is proper for male and female moral norms regarding sexual behaviour, physical activities, domestic ways of life etc. Patriarchal relationships are exemplified in religious symbolism where male deities are of a higher rank. Religious organisations have also excluded females from religious leadership roles in the past (McGuire: 132-6).

In the Thai Buddhist context, cultural products are based on the traditional essence of Theravada (Orthodox) Buddhism that is, according to Suntaree Komin, one of the leading social psychologists in Thailand:

?? to escape from the clutches of karma (ethical causation) and the cycle of rebirths (Samsara), by separating oneself from the world of illusions, and thereby gaining wisdom and insight into the karmically conditioned world, underlying the phenomenal world; and ultimately reach nirvana (final extinction)? (Komin 1990: 173).

The cultural product that Buddhist monks try to convey to Thai people through their preaching in the HIV/AIDS crisis is adherence to the Five Precepts: (1) abstain from taking life, (2) abstain from stealing, (3) abstain from sexual misconduct, (4) abstain from false speech, and (5) abstain from intoxicants that cloud the mind. This is not as simple as it sounds. The third precept is not practised in reality as pre-marital sexual relations for Thai men are culturally accepted, for most women they are not, and in many cases, extramarital sexual relations are tolerated by the female partners (Saengtienchai, Knodel, Vanlandingham & Pramualtratana 1999: 80-81). They summarize their report as follows:

?In the Thai context, these specific cultural features include a conception of male gender that places much emphasis on sexual drive and impulsiveness, a lack of emphasis on companionship within marriage, a view of commercial sex activity as a normal form of male entertainment, little stigma for regular commercial sex visitation by unmarried men, widespread acceptance by men and tolerance by some women of occasional commercial sex visitation by married men, a high value on harmonic social relations within a peer group context. All of these features serve to support the practice of extramarital sexual relations with commercial sex workers? (Vanlandingham, Knodel, Saengtienchai and Pramualtratana 1998: 17).

Therefore a participatory model, as derived from the multiplicity paradigm proposed by Jan Servaes, could strengthen democratic processes and institutions at the community level and redistribute power by people empowerment. People are the key agents of change. People?s strength and aspiration are the input in the process. The aim is to lift up the spirits of the local community to take pride in its own culture, intellect, and environment. People are actively improving themselves and the communities in order to reach a spiritual and ecological balance (Servaes 1999: 93).

This model chimes with Buddhist ideology and is, therefore, considered better if the democratic concept can be applied within a community. Kathleen Collins, who is an expert in participatory research, explained the importance of managing the health issues by the people and for the people as follows:

“In order to take responsibility for their own health, it is essential for people to understand the causes of disease, its origins and treatment. In order to co-operate with a lifestyle or treatment regime, people need to know its purpose and value. More than this, they have to know that they have a say in their lifestyle, otherwise they will feel imposed upon and will resist change. In other words, they have to ‘own’ their lifestyles, by feeling that they themselves have chosen them. Only when a lifestyle has been chosen by the people themselves, and not by outsiders, however ‘expert’ they may be, will they regard it as important enough to follow” (Collins 1999: 20).

#### Engaged Buddhism in HIV/AIDS prevention

The practice of using religion to help fight HIV/AIDS is not new. Historically both Christianity and Buddhism tried to scare people with hell if they are not good (Borthwick 1999: 212). These days, the emphasis is on moral and compassionate support for people living with AIDS and their families and, beyond that, prevention of the epidemic in a community. Religious leaders are respected in a community and have the potential to serve as effective resource persons because of their credibility and trustworthiness:

“Religious leaders are in the unique position of being able to alter the course of the epidemic. Why is that? Because religious leaders can: Shape social values; Promote responsible behaviour that respects the dignity of all persons and defends the sanctity of life; Increase public knowledge and influence opinion; Support enlightened attitudes, opinions, policies and laws; Redirect charitable resources for spiritual and social care and raise new funds for prevention and for care and support; Promote action from the grass roots up to the national level?”

(UNICEF &UNAIDS 2003, p.9).

The opening speech on 13 July 2004 of the Thai Minister of Public Health, Ms. Sudarat Kaeyuraphan, during the “Para-liturgical Celebration on Inter-faith Cooperation Activities” session of the 15th International AIDS Conference is illuminating about the engagement of religion in HIV/AIDS prevention. She stated that in combating AIDS:

“Religion is comparable to the spiritual and mental pillar of humankind as reflected in our culture and way of lives, largely at the community level. With its significant role, the religious institution has a great opportunity to invest in human life by allocating its resources early enough to conduct effective large-scale strategic intervention” (Inter-Faith Networking on AIDS 2004: 2).

Minister Kaeyuraphan also emphasized the importance of religion for loving, caring and sharing to assure that people living with HIV/AIDS were cared and loved for and did not suffer from stigma and discrimination. According to her, all sectors of society were working closely with religious organisations to prioritize HIV/AIDS interventions. She guaranteed the commitment from the highest levels of government and all sectors of society, including religious institutions, to necessary resources, people and funding (Inter-Faith Networking on AIDS 2004: 2-3).

#### **The “AIDS colony” versus the “community” approach**

Ven. Athorn Prachanart (a.k.a. Chao Khun Alongkot Tikapanyo or Phra Udom Prachathorn), the abbot of Wat Phra Baht Nam Phu in Lopburi Province, is a well-known abbot who has devoted his life to HIV/AIDS. He advocated the hospice approach, which emphasizes the admission of symptomatic- or terminal-stage AIDS patients into his hospice. This hospice, also called AIDS city, has operated since 1992 with the support of the International Network of Engaged Buddhists and AusAID (UNICEF, 2003: 1-4). It received monthly donations from the public of a total of about

1,200,000 Baths (US\$30,000) and a monthly budget of 100,000 Baths (US\$2,500) from the government (Watprabath Namphu, 2004).

In 1998, Ven. Athorn Prachanart caught the media's attention when he, together with the Thai Agricultural and Cooperatives Ministry, aimed to construct the world's first 'AIDS colony', in a centre about 100 kilometres North of Bangkok. This centre would shelter approximately 10,000 AIDS patients. HIV activists denounced his plan because they thought this would ostracize the AIDS patients and it would project the image that AIDS patients were difficult to care for (UPI 1998: 8).

In about the same year, another group of laymen and monks formed the Sangha Metta (the Compassionate Buddhist Monks) Project chaired by Mr. M, an Australian who spent 30 years of his life as a Buddhist monk. This group insists on having HIV/AIDS patients living in the same community as others while trying to increase awareness, knowledge and cooperation of the villagers to distinguish fears, stigma and discrimination. M explained his alternative approach as follows:

While Wat Phra Baht Nam Phu was initially intended to provide a place where people with HIV/AIDS who are unable to care for themselves, or who don't have families to care for them, can go for shelter and treatment, it has become known nationally as a place where people with HIV/AIDS can go. Consequently, people from all over Thailand are drawn there once they find they are HIV positive, rather than caring for themselves or investigating family support. In some cases, this precludes development of self-care and home-based care. As the work of the

hospice is highly publicized, the problem has arisen where the public associate HIV and AIDS with 'worse case scenarios' of sick and dying people with severe symptoms. Because of the large number of patients, quality all round treatment and care is also a challenge. Another problem the hospice faces is a high monthly operating cost, approximately Baht 3 million per month, which necessitates

constant and time-consuming fund-raising' (UNICEF 2003: 4-5).

### **Food for thought**

During the 15th International AIDS Conference about 50 Buddhist monks working on HIV/AIDS from all over the country released a so-called Integrating Interfaith Statement which raised the question whether monks should emphasise the five Buddhist Precepts only. Here a new concept emerged for boosting morality, instead of chanting the five precepts to people. The monks claim the need to use different techniques in their youth training, such as to let them understand that they have to repay their mothers by avoiding drugs or other high risk behaviours. One monk proposed that the eight noble paths (preaching the silas or the right speech, right conduct and right livelihood without giving proper knowledge about the issue) may not be suitable. Panya or wisdom in HIV/AIDS should be emphasised first, then silas (actions and effort), and then followed by smadhi or right mindfulness and concentration. If there is no wisdom on the issue, preaching about the right actions won't help. This view contradicts the order of attaining nirvana as laid down by Buddha.

This Integration Interfaith Statement may have serious implications for Thai Buddhism. Why? Because it fundamentally questions the traditional Thai-Buddhist worldview of the 'One Nation - One Religion' which has clouded the sangha as a Buddhist institution.

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